STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #72322 & 72385 and partial extended survey.	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility's census totaled 41 residents with 7 residents sampled. Based on interviews and record review the facility failed to ensure 1 resident (#3) was free from physical abuse. Findings included: - The closed record for resident #3 contained a Physician's Order Sheet (POS) dated 2/5/14 which included the diagnoses: hypertension (elevated blood pressure), Gastro esophageal reflux (backflow of stomach contents to the esophagus), cerebrovascular accident (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), and failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that can be seen in elderly individuals).	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 1	F 223		

The admission Minimum Data Set Assessment 3.0 (MDS) dated 12/24/13 documented the Brief Interview for Mental Status (BIMS) score of 2 which indicated the resident with severe cognitive impairment. The MDS further documented the resident required extensive assistance of 2 staff with transfers, dressing, toilet use, and personal hygiene, and extensive assist of 1 staff with bed mobility.

The cognitive Care Area Assessment (CAA) dated 12/31/13 documented the resident with the diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with cognitive loss, forgetfulness with poor recall, poor insight and judgment.

The communication CAA dated 12/31/13 documented the resident had difficulty with expressive and receptive communication and difficulty with new situations.

The initial care plan dated 12/17/13 documented the resident required assistance with activities of daily living due to weakness.

The undated addition to the care plan documented the resident's spouse could be abusive with the interventions to move the resident to a different room and to monitor spouse's behavior when they were together.

The nurses' notes documented on 12/17/13 the resident admitted post stroke and dementia. The resident was alert and oriented to self and unable to speak due to a ripped vocal cord.

The nurses' notes dated 12/21/13 at 12:00 P.M. documented an unnamed nursing staff observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 2	F 223		

another resident abused resident #3. The unnamed nursing staff stated another resident was beating resident #3 after asking this resident to transfer from a chair and when resident #3 was unable to transfer the other resident beat him/her.

The nurses' notes dated 12/22/14 at 10:30 A.M. documented resident #3 was alert and had expressive aphasia (unable to speak). The resident denied pain at this time. This resident had a bruise on the left side of his/her face and a swollen right hand. The staff placed resident #3 by the nurses' station for close monitoring.

The nurses' note dated 1/14/14 and timed 2:30 P.M. revealed this resident was hit on the right side of his/her face by another resident which stated he/she was trying to get resident #3's attention.

The nurses' note dated 1/20/14 at 12:15 P.M. documented resident #3 was alert and oriented to person only. The resident was aphasic and only able to answer yes/no questions.

On 3/13/14 at 1:10 P.M. licensed nursing staff I revealed nursing staff reported another resident was hitting and beating this resident. This resident rarely talked. The other resident was seen whipping the resident with a cane on his/her shoulder. The other resident would also hit him/her with his/her hand. Licensed nursing staff I saw another resident hit resident #3 on the side of his/her neck and placed the resident near the nurses' station for closer observation.

On 3/13/14 at 3:22 P.M. administrative nursing staff D revealed they were aware of the 4 incidents where this resident was hit by the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 3 resident. Licensed nursing staff D revealed they were not sure what the facility could have done to prevent abuse. On 3/13/14 at 4:10 P.M. licensed nursing staff J revealed an observation of resident #3 being hit by another resident with his/her fist in the activity room. Licensed nursing staff J placed the resident at the nurses' station to monitor him/her closer. On 3/14/14 at 9:27 A.M. direct care staff O revealed the resident was very quiet, rarely spoke, stood a little bit, but needed all cares to be done for him/her. The 9/11/13 revised facility policy "Abuse Reporting and Prevention" documented all suspicions and allegations must be taken seriously and acted upon, even if the allegation had occurred previously or repeated. Actions to protect the resident must be taken as if the allegation was true. The facility failed to protect this resident from abuse by another resident repeatedly. The facility failed to document an incident of abuse on 1/11/14 which staff documented in the resident's medical record that did the abusing.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4	F 225		

of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility's census totaled 41 residents with 7 residents sampled. Based on interviews and record review the facility failed to report allegations of abuse to the state survey and certification agency related to 1 resident (#3) of the sample.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 225	Continued From page 5	F 225		

Findings included:

- The closed record for resident #3 contained a Physician's Order Sheet (POS) dated 2/5/14 which included the diagnoses: hypertension (elevated blood pressure), Gastro esophageal reflux (backflow of stomach contents to the esophagus), cerebrovascular accident (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), and failure to thrive (includes not doing well, feeling poorly, weight loss, poor self-care that can be seen in elderly individuals).

The admission Minimum Data Set Assessment 3.0 (MDS) dated 12/24/13 documented the Brief Interview for Mental Status (BIMS) score of 2 which indicated the resident had severe cognitive impairment. The MDS further documented the resident required extensive assistance of 2 staff with transfers, dressing, toilet use, and personal hygiene, and extensive assist of 1 staff with bed mobility.

The cognitive Care Area Assessment (CAA) dated 12/31/13 documented the resident with the diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with cognitive loss, forgetfulness with poor recall, poor insight and judgment.

The communication CAA dated 12/31/13 documented the resident had difficulty with expressive and receptive communication and difficulty with new situations.

The initial care plan dated 12/17/13 documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 225	Continued From page 6	F 225		

the resident required assistance with activities of daily living due to weakness.

The undated addition to the care plan documented that the resident's spouse can be abusive with interventions to move the resident to a different room and to monitor spouse's behavior when they were together.

The nurses' notes documented on 12/17/13 the resident admitted with the diagnoses of post stroke and dementia. The resident was alert and oriented to self and unable to speak due to a ripped vocal cord.

The nurses' notes dated 12/21/13 at 12:00 P.M. documented an unnamed nursing staff member observed another resident abusing resident #3. The unnamed nursing staff stated another resident beat resident #3 after asking him/her to transfer from a chair and when this resident was unable to transfer the other resident beat resident #3.

The nurses' note dated 12/22/14 at 10:30 A.M. documented resident #3 was alert and had expressive aphasia (condition in which language function is disordered or absent).

Resident #3 denied pain at this time but had a bruise on the left side of his/her face and a swollen right hand. Staff placed this resident by the nurses' station for close monitoring.

The nurses' note dated 1/14/14 at 2:30 P.M. revealed resident #3 was hit on the right side of his/her face by another resident who stated he/she was trying to get resident #3's attention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7	F 225		

The nurses' note dated 1/20/14 at 12:15 P.M. documented resident #3 was alert and oriented to person only. The resident was aphasic (condition in which language function is disordered or absent) and only able to answer yes/no questions.

On 3/13/14 at 1:10 P.M. licensed nursing staff I revealed nursing staff reported another resident was hitting and beating resident #3. Staff saw this resident whipping resident #3 with a cane on his/her shoulder. The other resident would also hit resident #3 with his/her hand. Licensed nursing staff I saw the resident hit resident #3 on the side of his/her the neck and staff placed the resident near the nurses' station for closer observation.

On 3/13/14 at 3:22 P.M. administrative nursing staff D revealed they were aware of the 4 incidents where resident #3 was hit by the same resident. Licensed nursing staff D revealed they were not sure what the facility could have done to prevent abuse.

On 3/13/14 at 4:10 P.M. licensed nursing staff J revealed an observation of resident #3 being hit by another resident with his/her fist in the activity room. Licensed nursing staff J placed the resident at the nurses' station to monitor him/her closer.

On 3/14/14 at 9:27 A.M. direct care staff O revealed the resident was very quiet, rarely spoke, stood a little bit, but needed all cares to be done for him/her.

Administrative nursing staff D on 3/13/14 at 3:22 P.M. stated the four incidents of resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8 resident abuse was not reported to the state. The 9/11/13 revised facility policy "Abuse Reporting and Prevention" documented the allegation of abuse must be reported to law enforcement, the regulatory agency, and the local protective service agency, as required by applicable law and regulation, within the time frames and through the format required by the applicable law and regulation. The facility failed to investigate and report 4 reportable incidents related to physical abuse of resident to resident to the State survey and certification agency as required.	F 225		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility's census totaled 41 residents with 3 residents sampled for elopement. Based on observation, interview, and record review, the facility failed to provide adequate supervision for an independently mobile cognitively impaired resident with a history of falls, to prevent 1 (#1) resident from leaving the facility without staff knowledge which put this resident in immediate jeopardy.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

Finding included:

- The closed record for resident #1 contained a Physician's Order Sheet (POS) dated 1/5/14 which included the diagnoses: closed head injury from a previous fall, hypertension (elevated blood pressure), and dementia (progressive mental disorder characterized by failing memory, confusion).

The admission Minimum Data Set 3.0 assessment (MDS) dated 12/23/13 documented the Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. The MDS further documented the resident with behaviors of inattention and disorganized thinking, required limited assistance of 1 staff with bed mobility and supervision with dressing, toilet use and personal hygiene. The resident's balance was not steady, but was able to stabilize without the assistance of the staff and used a cane for mobility. The MDS further documented the resident had a fall with fracture in the last month prior to admission.

The cognition Care Area Assessment (CAA) dated 12/30/13 documented the resident had cognitive deficits related to his/her dementia diagnosis. The resident had periods of confusion, memory loss, and needed the staff to redirect and reorient.

The communication CAA dated 12/20/13 documented the resident had difficulty with receptive and expressive communication, cognitive deficits, visual impairment, and was hard of hearing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

The fall CAA dated 12/20/13 documented the resident was at risk for falls related to decreased functional and physical status, had an unsteady gait, and required a wheelchair for mobility.

The 12/16/13 care plan related to falls documented the following interventions: use of a bed alarm due to a history of falls and to keep the bed in a low position to prevent injuries related to falls. The resident was at risk for falls due to impaired safety awareness because of his/her dementia.

The Skilled Nursing Health and Service Evaluation/Assessment (admission form) dated 12/16/13 at 6:45 P.M. documented the following fall risk factors: history of falls, dementia, impaired vision (wore glasses), and a history of hypertension.

The clinical record lacked evidence of an elopement assessment.

The nurses' note documented on 1/25/14 at approximately 6:40 P.M. resident #1 was found walking down the sidewalk with a cane outside the facility. Resident stated he/she was "going home". The resident was alert and oriented to self and time but could be more confused at times. The resident was redirected and assisted back into the facility without incidence. The resident was unharmed. The resident's temperature was 96.8 degrees Fahrenheit (F). A Wanderguard (a monitoring device worn by a resident to prevent an elopement) was placed on the resident's left ankle. The resident was placed on 15 minute checks and slept most of the night.

Nurse's note dated 1/26/14 at 9:15 A.M. revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

after breakfast the resident immediately went to the east door and attempted to go out. The alarm sounded, the resident went outside and the nursing staff brought the resident back inside the building. Staff moved the resident to the locked memory neighborhood for additional safety reasons.

On 1/26/14 at 11:30 A.M. the resident was angry with the situation and continued to exit seek.

Wunderground.com recorded on 1/25/14 at 6:53 P.M. the air temperature was 30 degrees Fahrenheit with a wind chill temperature of 26.5 degrees.

Observation of the east, west, south, north, and dining room exit doors on 3/12/14 from 3:40 P.M. to 3:50 P.M. revealed all the doors alarmed when opened. Observation of the main entrance doors revealed two automatic doors that opened with a keypad or a switch activated at the nurses' station. The inner door stayed open for 25 seconds and the outside door remained open for 20 seconds after the doors were activated.

Housekeeping/Maintenance staff X on 3/13/14 at 1:00 P.M. stated the facility checked the exit doors one time a month. He/she provided the maintenance log that showed he/she had checked all the doors in the last month.

Administrative nursing staff D on 3/13/14 at 3:22 P.M. stated the facility assumed the resident eloped from the front door of the facility.

On 3/14/14 at 10:00 A.M. observation of the route the resident walked, was a quarter of a mile from the facility with a slight incline from the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

front door to a busy 4 lane roadway with speed limit of 30 miles per hour, then to a sidewalk very close to the roadway.

On 3/13/14 at 3:22 P.M. administrative nursing staff D revealed the resident did leave the building without staff knowledge and was down the road by the church and did not think the resident could have walked any further as he/she was very tired when brought back into the building.

The facility's investigation revealed staff last saw the resident at 6:15 A.M., pushing his/her spouse down the hallway and then at 6:25 P.M. sitting in the activity room watching television. The investigation did not reveal if door alarms were activated.

On 3/14/14 at 9:30 A.M. licensed nursing staff H revealed that he/she was driving away from the facility for supper on the evening of 1/25/14 at approximately 6:30 P.M. Licensed nursing staff H stated he/she drove out of the facility driveway and went south on a busy 4 lane road and saw an elderly gentleman walking with a cane on the sidewalk going south, away from the facility. Licensed nursing staff H was unsure if the man was one of the facility's residents because it was dark and he/she could not see who the elderly man was, so he/she went back to the facility and checked to see if any of the residents were missing. The nursing staff was unable to find resident #1 in the facility. Licensed nursing staff H had another nursing staff go with him/her to get the resident. The resident was dressed in a pair slacks, a sweater over a long button down shirt. Licensed nursing staff H revealed the resident did not have enough clothing on for the weather as it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

was a very chilly night.

On 3/14/14 at 2:00 P.M. direct care staff P revealed on 1/25/14 licensed nursing staff H left for supper and came back to the facility and asked him/her to go with him/her as he/she saw one of our residents walking down the street. Direct care staff P left with licensed nursing staff H and went and got the resident and brought him/her back to the facility. Direct care staff P revealed he/she placed a Wanderguard device on the resident's right ankle when maintenance staff gave the device to him/her.

The revised February 3, 2014 facility policy "Elopement Risk: Prevention and Safeguarding Residents" documented the purpose of the policy and procedure was to address methods to reduce the incidence of elopement and enhance resident safety. The potential for elopement was evaluated and documented by the health care coordinator or licensed nurse. Examples of behaviors or conditions that could indicate a resident was at risk of elopement: a resident with cognitive impairment moving aimlessly or wandering inside a building, not oriented to place (could not find way back and would not know the address of the community), and/or left the facility without signing out and not informing the community.

The facility failed to provide a secure environment for this wandering, cognitively impaired, ambulatory resident who had a history of falls, who went out an unknown exit door, walked up a slight inclined driveway to a busy 4 lane roadway and down a sidewalk for approximately a quarter of a mile unsupervised and without staff knowledge, which put this resident at immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 The facility abated the immediate jeopardy on 3/19/14 at 2:00 P.M. when the facility reassessed this resident and placed a wanderguard on him/her until the resident was discharged from the facility. The Director of Nursing reassessed all residents that had a cognitive impairment and were potentially at risk of exhibiting exit seeking or elopement behaviors. The facility added interventions and/or strategies to minimize and /or prevent exit seeking or elopement behaviors to the care plans as/if necessary. The Executive Director, Director of Nursing, or designee trained all team members on community policies, procedures, and protocols regarding minimizing and/or preventing elopement and exit seeking behaviors, and the process of investigating elopements completed on 3/19/14 at 2:00 P.M. The Executive Director or designee would be responsible for ensuring implementation and ongoing compliance with all components of the Plan of Correction and addressing and resolving any variance that may occur. The Executive Director or designee would be responsible for ensuring the status of this Plan of Correction was reviewed and discussed at Quality Assurance/Performance Improvement Meetings and action initiated as/if required. This deficient practice remains at a scope and severity of a D.	F 323		